Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

# NURSE DELEGATION: INITIAL DELEGATION, SUPERVISION OR RESCINDING DELEGATION

| RESIDENT'S NAME (LAST, FIRST, MIDDLE INITIAL) | DATE OF BIRTH (MM/DD/YYYY) | CLIENT ID NUMBER |
|---|---|---|
| | | |

Delegated Task(s): ☐ Initial Delegation ☐ Ongoing Supervision

Include date, client/patient care outcomes, observations of nursing assistant's performance, and if redemonstration or remedial training was necessary. Explain any negative outcomes and action taken. May complete for multiple NA-s if all are performing task adequately.

(Specific Instructions on next page(s))

Client Status: ☐ Stable and Predictable ☐ Changes (See Note)

Review of systems: Charting is problem oriented. Only new or significant changes or problems are noted in detail although a complete review was done. Checked box indicates notes below.

| | | |
|---|---|---|
| ☐ Activity | ☐ Endocrine | ☐ Neuropsych |
| ☐ Appetite | ☐ GI/GU | ☐ Respiratory |
| ☐ Cardiac | ☐ Hearing | ☐ Skin |
| ☐ Cognition | ☐ Musculoskeletal | ☐ Vision |

Name(s) of NA(s) Evaluated: _____

Nursing Assistant Competence:

☐ Return demonstration ☐ Other: _____

☐ Verbal description _____

☐ Teaching needed/completed _____

Negative Outcomes:

☐ None ☐ Comments: _____

_____

Continue Delegation: ☐ Yes ☐ No (rescind below)

Note: _____

_____

_____

Return supervision on/before: _____

| RN'S SIGNATURE | DATE | NA'S SIGNATURE | DATE |
|---|---|---|---|
| | | | |

☐ **RESCINDING DELEGATION**

(Complete Resident Name, Date of Birth and Social Security Number Above)

Reason Rescinding:

☐ Resident died ☐ Other: _____

☐ Resident transferred _____

☐ Resident condition improved _____

Alternative Plan: ☐ None needed ☐ Details of plan below

_____

_____

_____

| RN'S SIGNATURE | DATE | NA'S SIGNATURE | DATE |
|---|---|---|---|
| | | | |

DSHS 13-680 (REV. 12/2002) (AC 01/2003)

**To register concerns or complaints about Nurse Delegation, please call 1-800-562-6078 Toll Free.**

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